WORLD HEALTH ORGANIZATION

TOBACCO ALERT

APRIL 1992

EDITORIAL

TOBACCO CONTROL IN AFRICA

Tobacco use worldwide is currently killing three million people each year and the African contribution to this figure, while still low, is rising rapidly. Although infectious diseases will continue for some time to be the main causes of death in the developing countries of Africa, tobacco, due to rising consumption, will soon begin to gain prominence.

This phenomenon will need to be closely documented and I hope that energy and resources will be made available for this purpose as, unfortunately, there is still a general lack of information regarding the patterns and prevalence of tobacco consumption among African countries. However, a few surveys carried out on specific groups, such as students, indicate that the young tend to emulate the smoking habits of those considered to be sophisticated or advanced. For example, in 1973, fewer than 3% of Nigerian female students smoked; but by 1982 the figure had risen to 24% among female university and polytechnic students and 52% among female trainee teachers; these students will now be in positions where they will set an example to the community at large.

Of particular concern is the fact that advertising by tobacco companies, using sophisticated and often foreign models, is now being used in Africa as has been done in developing countries of other continents. Radio and TV networks and the printed press welcome the financial support offered by the tobacco industry, and use their facilities to promote smoking, particularly among the young.

Recognizing the need for preventive action to avoid the looming epidemic, a number of African countries have already taken action and efforts to fight against the tobacco epidemic are under way; for example, in Nigeria, Mozambique and Sudan, laws have been passed prohibiting smoking in public places and schools. Moreover, the law in Nigeria stipulates that warnings must appear on all cigarette packaging indicating that smoking is injurious to health; tar and nicotine content must also be stated. Much remains to be done and legislation is a powerful and indispensable tool for preventing the advance of the tobacco epidemic.

However, we must note the concern expressed by the few African countries that depend heavily on tobacco production for their economic and health development. For their sake, important matters such as crop substitution, agricultural diversification and economic support must not be neglected, and measures will have to be taken progressively to compensate their income as tobacco production is decreased; as a step in this direction, the Director-General of WHO presented these considerations in his report to the meeting of the Economic and Social Council of the United Nations (ECOSOC) in July 1991.

Tobacco is already a very important issue in my country and the challenge facing other African countries is to prevent smoking from reaching the scale found in developed countries, particularly because increased tobacco production threatens to undo much of the progress made in health development in our continent.

Professor O. Ransome-Kuti

Minister of Health and Human Services, Nigeria
Chairman of the Eighty-ninth Session of the Executive Board of the World Health Organization

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WHO/TOH PROGRAMME

TOBACCO OR HEALTH ISSUES AT THE WHO GOVERNING BODIES

The Constitution of the World Health Organization recognizes three types of governing bodies each with specific functions: 1. the **World Health Assembly** which, **inter alia,** determines the policies of the Organization; 2. the **Executive Board** which gives effect to the decisions and policies of the World Health Assembly and may also offer advice or submit proposals on its own initiative; and 3. the **Regional Committees** which formulate policies governing matters of a regional nature.

All these bodies have been intermittently concerned with Tobacco or Health over the past 20 years, and recently the issue has been featured prominently by Regional Committees. Furthermore, it has been discussed at each meeting of the World Health Assembly and Executive Board during the past six years.

Previous issues of **Tobacco Alert** (July 1990 and July 1991) have already reported on the World Health Assembly discussions on Tobacco or Health.

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EPIDEMIOLOGY

SMOKING AND MORTALITY FROM CARDIOVASCULAR DISEASES

Surveys of public opinion on the principal health effects of cigarette smoking have typically identified such diseases as lung cancer, chronic bronchitis and emphysema as the leading causes of death due to smoking, with many respondents even being unaware of the link between smoking and heart diseases. While in **relative** terms the risk of a smoker dying from these diseases is significantly higher than from vascular diseases, death from one of the cardiovascular diseases (CVD) among smokers is much more common due to the substantially greater number of deaths from CVD compared with other causes. Indeed, of the total of approximately 11 million deaths which occur each year in the developed countries, more than half (6 million) are due to circulatory diseases (2.5 million from ischaemic heart disease, 1.5 million due to stroke, and 2 million from other vascular diseases) compared with 500 000 lung cancer deaths, 1.9 million deaths from other forms of cancer and just under 500 000 deaths, from chronic bronchitis, emphysema and associated conditions. Thus, even a modest increase in the risk of death from cardiovascular diseases among smokers can be expected to result in a substantial number of CVD deaths each year due to smoking.

The injurious effects of smoking are not limited to the smoker but also affect non-smokers. There is extensive literature showing a higher risk of heart disease death in non-smokers married to smokers and the risk increases with the amount smoked by the spouse; similar effects can be expected in other circumstances such as public places or work places. This article, which is concerned with estimates of the **direct** effect of smoking on cardiovascular disease mortality, thus provides a conservative estimate of CVD deaths due to smoking.

Epidemiological studies have confirmed that this excess mortality risk among smokers is 2 to 4 times higher than among non-smokers, with comparatively little variation in excess mortality among the major circulatory diseases, namely ischaemic heart disease and cerebrovascular lesions. On the other hand, there is a marked age-differential in excess risk for smokers, with the greatest relative excess mortality among smokers being at young adult ages. At ages 35-59 years, smokers incur a 3.5-fold excess risk of death from cardiovascular disease compared with lifelong non-smokers, with the relative risk progressively declining, but nevertheless still significant (1.5), at older ages (75 years and over).

It is this marked excess mortality during adulthood which distinguishes the smoking-attributable CVD deaths from other causes such as lung cancer, for which the peak in excess mortality risk is attained much later in life. Thus not only do vascular diseases claim as many lives each year in the developed countries (600 000) due to smoking as all forms of cancer combined, but, moreover, they are the **leading cause of premature death** as a result of smoking.

The World Health Organization has recently prepared estimates of annual smoking-attributable mortality according to age, sex and cause of death for those countries (primarily developed countries) for which reliable and complete cause of death data are available. The estimates are based on the excess mortality risks of smokers compared with non-smokers (as observed in the United States), suitably scaled to allow for the different cumulative exposures (i.e. the "*maturity*" of the epidemic) in various countries. The observed lung cancer rate in a given population was used to determine the extent of the epidemic; in populations where lung cancer mortality is high, it is likely that mortality from other smoking-related diseases, such as ischaemic heart disease and stroke, will also be substantial.

Figure 1 summarizes the estimated annual premature adult mortality among males (defined here as a death prior to 70 years) in developed countries due to smoking, and the specific contribution of smoking-attributable CVD deaths to this appalling human toll. Estimates for selected developed countries are given in Table 1.

On average, about one-third of all premature male deaths at ages 35-69, which typically encompass the peak years of earning capacity, are directly attributable to cigarette smoking. Of these deaths (estimated at 800 000 per year among men alone), almost 40% or 300 000 occur due to circulatory diseases. Moreover, these 300 000 premature CVD deaths due to smoking represent one-third of all CVD deaths at ages 35-69 years, i.e. on average, one in three premature CVD deaths among males is directly attributable to smoking.

Among women, the proportionate

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Figure 1 Premature adult male mortality due to smoking in developed countries, 1990

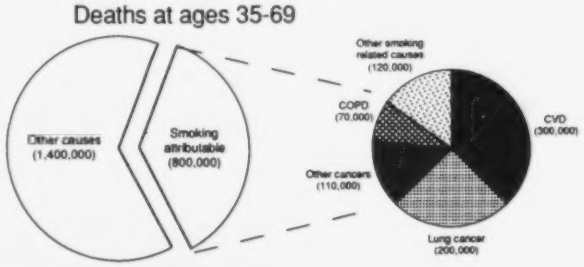

Table 1 Estimated smoking attributable CVD mortality, selected developed countries, 1990

Country	MALES 35-69	MALES All ages	FEMALES 35-69	FEMALES All ages	TOTAL 35-69	TOTAL All ages
Denmark	1 300	2 600	400	1 100	1 700	3 700
Hungary	6 000	9 100	1 000	2 400	7 000	11 500
Japan	6 000	15 000	1 200	6 000	7 200	21 000
Poland	15 600	22 000	1 700	3 200	17 300	25 200
United Kingdom	19 000	37 000	6 400	18 000	25 400	55 000
United States	9 000	98 000	24 000	52 000	83 000	150 000
EEC (12)	70 000	140 000	10 000	30 000	80 000	170 000
All developed countries	300 000	480 000	55 000	120 000	355 000	600 000

Source: WHO estimates

EPIDEMIOLOGY

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mortality due to smoking is somewhat lower given their later onset, and generally lower prevalence of persistent smoking. Just over 10% of CVD deaths among women aged 35-69 are estimated to be due to smoking. Similarly, about 10-12% of all female deaths at these ages are smoking attributable, although this proportion is expected to rise significantly as the full effects of past and present consumption trends become evident. This tendency is already apparent at younger ages in those countries (e.g. Denmark, United Kingdom, and the United States) where women first began to smoke in large numbers, with up to one-quarter of all premature CVD deaths among females being directly attributable to smoking.

WHO/TOH PROGRAMME

SECOND EUROPEAN SEMINAR ON TOBACCO OR HEALTH, BUDAPEST, HUNGARY

Over 70 participants from 28 European countries gathered in Budapest from 22-24 January 1992 for the Second European Seminar on Tobacco or Health for National Policy Advisers and National Programme Managers. The meeting was held under the auspices of the Tobacco or Health Programme in the Regional Office for Europe of the World Health Organization and hosted by the WHO Collaborating Centre for Tobacco Epidemiology in Budapest.

Participants did not have to wait long to be confronted by the problems of tobacco advertising and tobacco consumption in Hungary. Newly minted tobacco advertisements in shop windows and roadside billboards everywhere in Budapest entice Hungarians to risk death and illness by smoking brands of cigarettes that have become all too familiar in other parts of the world. Multinational tobacco companies have found a large potential market in Hungary for their Western-style cigarettes. Even before Hungary opened its doors to Western-style tobacco advertising, prevalence of smoking and of smoking-related deaths were among the highest in the world.

Progress in France, Poland and Canada

Participants heard of encouraging progress in tobacco control in France, Poland and Canada.

France recently passed a new tobacco control law that provides for a complete ban on tobacco advertising, improved health warning labels on packages of cigarettes, and legislative authority for regulation of smoking in public places and workplaces. The new law will be progressively implemented, and become fully operational in 1993.

Poland, like Hungary, has high rates of tobacco consumption and tobacco-related mortality. Participants learned that concrete steps are being taken in Poland to deal with this serious problem. Plans for the implementation of comprehensive tobacco control policies have been formulated and have recently been the subject of debate in the Polish Parliament. Some aspects of the policy have been implemented. There has been an increase in health promotion and education campaigns in favour of a tobacco-free lifestyle. New smoking cessation programmes have also been implemented, as have controls on smoking in public places and transport vehicles. However, comprehensive legislation, including a ban on tobacco advertising has not yet been passed by the Seym (Parliament).

Canada now has had over three years of experience with comprehensive tobacco control policies, including a legislated prohibition of tobacco advertising. Since the policy was implemented, tobacco consumption has fallen at a faster rate than ever before. Even so, smoking prevalence is still around 30% of adults, and continued application of this comprehensive policy will be needed to further reduce Canadian smoking prevalence.

Assessing progress towards a smoke-free Europe

In 1987, the WHO Regional Committee for Europe adopted a five-year ***Action Plan on Tobacco.*** This ambitious plan outlined objectives and timetables that would be needed to lead towards the adoption of comprehensive tobacco control policies by 1992, so that the Health for All targets for 1995 of a minimum of 80% non-smokers in each country, and a 50% reduction in tobacco consumption would be met. (See article entitled *"Tobacco or Health issues at the WHO governing bodies".*)

In reviewing progress towards these objectives, participants were suitably encouraged. One group of countries has had comprehensive tobacco control policies for some time. Most of these countries have recently implemented new measures to further strengthen their tobacco control policies.

Other countries have taken positive steps towards implementing the *Action Plan*, but their actions are too recent for effectiveness to be assessed, or their actions, while representing progress, fall short of the comprehensive programmes called for in the *Action Plan.*

In a third group of countries, few, if any, actions have been taken to control tobacco. In many of these countries, tobacco consumption is still increasing.

While participants noted that there had been very encouraging progress made in many countries, overall results fell short of the targets and objectives. It was concluded:

"Unless present trends change dramatically, it is now clear that the European Region of WHO will fail to reach its target of reducing tobacco consumption by 50% by 1995 and that no country will succeed in having 80% of its population as nonsmokers by the same date. While a small number of countries may reach these goals by the year 2000, overall the number of tobacco-related deaths is expected to continue to increase."

Already, the number of tobacco-related deaths each year in Europe exceeds one million.

The next steps

In September 1991, the WHO Regional Committee for Europe met in Lisbon and noted that there had been delays in achieving targets for the reduction of smoking. They then passed a resolution calling on Member States to increase their efforts in this area, and asked the Regional Director to collaborate with Member States and intergovernmental organizations to develop a draft *second Action Plan* for a tobacco-free Europe for the period 1992 to 1996.

Participants in Budapest studied the Resolution of the Regional Committee for Europe and agreed that the content of the *first Action Plan* was not flawed in any fundamental way. However, implementation was already behind schedule, and greater efforts were needed on the part of Member States if there was to be any hope of finally containing the tobacco epidemic. Increased international cooperation, the development of national and international alliances for health, and focused national and international collaboration to solve specific policy implementation problems were some of the specific ideas mentioned for improving the implementation of comprehensive tobacco control programmes.

The effectiveness of international collaboration has already been vividly demonstrated. On the final day of the Seminar, 24 January 1992, the meeting considered and passed a resolution calling on EC countries to legislate the proposed directive to ban tobacco advertising. It was stressed that adoption of this measure was of great importance because the actions of the twelve-nation European Community would serve as a model for the new and renewed democracies of Eastern and Central Europe.

While it can never be known exactly what influence this resolution may have had, it is known that on 11 February 1992 the European Parliament at Strasbourg voted in favour of the proposed ban on advertising in the European Community. The proposal must now receive the support of two-thirds of the Council of Health Ministers before becoming law.

READEX FICHE

SOCIETY

ADVERTISING OF TOBACCO PRODUCTS: SEVEN EUROPEANS OUT OF TEN IN FAVOUR OF A BAN AND THE IDEA IS SPREADING IN OTHER COUNTRIES

A "*Eurobarometer*" survey, carried out in October 1991 among 12 800 people of 15 years or over in the 12 member states of the European Community, confirms the results of a previous survey carried out in March-April 1987: 73% of the persons questioned were in favour of legislation banning all forms of advertising, direct or indirect, of tobacco products.

In 1991, the countries most in favour of the ban were Portugal (88%) and Italy (85%), which have already adopted legislation on this subject. The least in favour were the Netherlands (55%) and Denmark (53%). In Germany, those in favour of the ban (73%) were more numerous in the former East Germany (80%) than in the former West Germany (70%).

	March-April 1987 %		October 1991 %	
For: very much	)		51	
	)	73		73
For: to some extent	)		22	
Against: to some extent	)		13	
	)	21		19
Against: very much	)		6	
No answer		6	8	
TOTAL		100	100	

On average, a larger number of non-smokers (78%) were in favour of the ban; these constitute two-thirds of the population questioned. However, even among smokers, a large majority (64%) were also in favour of a ban on the advertising of tobacco products. As might be expected, the intensity of the opinion expressed varies according to behaviour: in the majority of countries, far more non-smokers than smokers declare themselves "*very much for*" the ban, whereas smokers frequently adopt the more moderate position of "*to some extent for*".

SMOKERS AND NON-SMOKERS ON THE BANNING OF ADVERTISING

	B %	DK %	D %	GR %	E %	F %	IRL %	I %	L %	NL %	P %	UK %	CE12 %
Smokers													
for-very much	33	31	32	62	47	25	49	54	33	24	48	48	40
for-to some extent	29	22	26	16	21	27	25	27	28	23	36	19	24
Total	62	53	58	78	68	52	74	81	61	47	84	67	64
Non Smokers													
for-very much	54	33	60	65	59	46	67	72	50	38	66	54	58
for-to some extent	24	21	19	15	23	25	12	15	25	24	24	19	20
Total	78	54	79	80	82	71	79	87	75	62	90	73	78

On 11 February 1992 the European Parliament adopted, at the first reading, a proposal for a directive banning all advertising for tobacco products, except at the points of sale of such products. The vote in favour of a ban – 150 for, 123 against and 12 abstentions – was achieved despite the lobbying campaign by the tobacco industry and advertising agencies which some members of parliament publicly denounced as excessive, and which was described in the press as "*the largest and best-financed lobbying campaign ever mounted by tobacco and advertising companies*".

This vote, which confirms the public support for a ban on tobacco advertising, will have an important but not a decisive influence on the health ministers of countries of the European Community. Under the Community legislative process, the final decision is in the hands of the Council of Ministers, and the European Parliament has only advisory powers.

The Council of Ministers of Health of the 12 Member States will examine the proposal for a directive on 15 May this year. Most countries are in favour of the ban on tobacco advertising, but some are still opposed to it and may block its adoption. The outcome of the meeting of the Council is therefore still in the balance.

Smoking is one of the leading

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SOCIETY

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causes of death in the countries of the Community and, as Professor Claude Got pointed out recently, the interests of all must be dealt with at a collective level and the State has the duty to react on behalf of public health.

Moreover, a ban on tobacco advertising should not have serious consequences for the economic situation. In the European Community, tobacco advertising accounted for only 1.6% of total advertising expenditure in 1988. As regards tobacco advertising in the press, expenditure in 1990 represented only 1.1% of the total advertising budget in France, 2.8% in the Netherlands, 1.8% in Belgium and 2.4% in the United Kingdom.

Some protesters against the draft directive on the banning of tobacco advertising set themselves up as defenders of *"freedom of information"*. However, freedom of information also means there should be an opportunity to defend all opinions. The International Union against Cancer suggests that the press should provide advertising space for the message: *"Let us give our children an opportunity for a healthy future – without tobacco advertising, of course"*.

The **Journal of the American Medical Association** published a series of articles in December 1991 on advertising and children, which indicate that:

- *"Very young children see, understand and remember advertising. Given the serious health consequences of smoking, the exposure of children to environmental tobacco advertising may represent an important health risk and should be studied further."*
- *"Some recent cartoon-style advertisements are far more successful at marketing cigarettes to children than to adults. This finding is consistent with tobacco industry documents that indicate that a major function of tobacco advertising is to promote and maintain tobacco addiction among children."*
- *"Perception of advertising is higher among young smokers; market-share patterns across age and sex groups follow the perceived advertising patterns; and changes in market share resulting from advertising occur mainly in younger smokers. Cigarette advertising encourages youth to smoke and should be banned."*

Similar findings are being seen in other parts of the world; in October 1991 a New Zealand research team published (British Journal of Addiction) an analysis of data on tobacco consumption, price and advertising covering 22 OECD countries over a 27-year period. The study concludes that full restrictions on the advertising of tobacco products, combined with a price policy, had a significant influence on the level of consumption during those 27 years. Moreover, the more complete the ban, the greater was the effect in reducing consumption. Recent similar studies in Canada since January 1989 and in New Zealand since October 1990 display the same effects.

In these and other countries, there is a growing awareness by governments of the need to protect their citizens and avoid promoting a hazard for mere commercial interest.

NEWS BRIEF

PARLIAMENTARIANS AND SMOKING: THE AMERICAN EXAMPLE CATCHES ON

In the July 1990 issue of **Tobacco Alert,** we reported a survey of smoking habits among members of the US Congress. This interesting initiative has, apparently, inspired some Hungarian physicians to carry out a similar kind of survey among members of the Hungarian Parliament, using an anonymous questionnaire. One-hundred-and-fifty-five Hungarian deputies replied, a response rate of 61%. It emerges that 29% of the Hungarian parliamentarians who replied are smokers, while 35% are non-smokers and 36% former smokers.

Although it gives only an approximate picture of the situation, as more than one-third of the deputies did not reply, this survey is of considerable importance in that it reflects a growing awareness of the problem of smoking and its repercussions on health. This is evidenced by the impressive number who have given up smoking and by the organization of a national No-Tobacco Day in Hungary on 13 November 1991. The Hungarian organizers focused their national day on the fight against smoking in the workplace, stealing a march on WHO, which has adopted this theme for World No-Tobacco Day 1992. Various aspects were highlighted, from the dangers of passive smoking to the risks of lung cancer, the consequences in terms of cardiovascular diseases and the urological effects of smoking.

In spite of the many economic and social problems Hungary is facing, this increased commitment to the control of smoking is encouraging and augurs well for the future health of a country that is famous for the number and assiduity of its smokers.

WHO/TOH PROGRAMME

TOBACCO OR HEALTH ISSUES AT THE WHO GOVERNING BODIES

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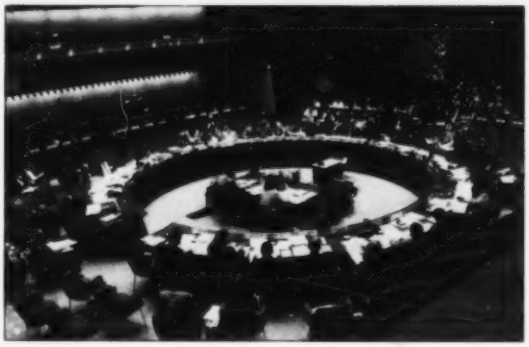
The following is a summary of the most recent Executive Board debate (January 1992), together with highlights of the discussions on tobacco control at some of the Regional Committees.

Delegates at the Forty-fourth World Health Assembly (see **Tobacco Alert** of July 1991) had agreed that the Director-General of WHO should bring the social and economic issues of tobacco production and consumption to the attention of the United Nations Economic and Social Council (ECOSOC), a more appropriate forum to debate such facets as agricultural diversification, taxes on tobacco products, and other industrial and tobacco trade matters, with a view to involving the other organizations of the United Nations system which are competent in this area.

Concern had also been expressed by the delegates regarding the possible conflict between carefully set priority activities for the Tobacco or Health programme and additional demands which do not always fall in line with WHO's range of approaches. As a result, it was agreed that the focus of activities for the Tobacco or Health programme be reassessed by the Executive Board at its Eighty-ninth session in January 1992, with a view to advising on the selection of future orientations.

An information document highlighting the actions taken by the Director-General in bringing the economic and social issues of tobacco production and consumption to the appropriate fora in the United Nations system was thus submitted to the Eighty-ninth session of the Executive Board. The document also explained the orientation of the WHO/TOH programme and the ways in which its priority activities were selected; the priority activities in support of the development of national tobacco control programmes were restated.



Members of the Board were quite unanimous in agreeing that the document illustrated the conflict between the need to reduce the high toll of disease and death as a result of tobacco use and the potential economic impact of WHO policies designed for this purpose on tobacco-producing countries. They reaffirmed that a multisectoral approach was required to cope with the innumerable social and economic issues associated with tobacco production and consumption. WHO's attempts to involve other United Nations agencies and the World Bank in addressing such issues were commended.

The utilization of part of the Tobacco or Health programme's limited resources for the development of national tobacco control programmes that included the promotion of public education and the creation of a database, was welcomed but it was also stated that great emphasis should be placed on prevention. It was recognized that a substantial reduction in tobacco consumption would only be achieved by changing individual attitudes. Such changes must be brought about by education, information and motivation, activities that must receive great attention among those planned by the Tobacco or Health programme.

WHO's mandate as a health agency means that it would be judged in terms of how successful its work in the health-related areas of tobacco had been. The Organization might be reproached for not being vocal enough in its declaration of tobacco consumption as a major public health problem. It was agreed that WHO needed to legitimize its actions vis-à-vis other United Nations bodies, whose cooperation was essential, by drawing attention to the severity of a health problem for which it shared joint responsibility.

Dr Ntaba, Minister for Health of Malawi, reminded members of the Executive Board of the economic effects on the tobacco-dependent countries should there be a reduction in tobacco production. Despite WHO's desire to help tobacco-producing countries to find tobacco substitutes (as expressed in numerous resolutions), there was still no alternative crop available. Dr Ntaba therefore requested the Board to suggest to the Forty-fifth World Health Assembly that it place tobacco on the agenda of the United Nations General Assembly, with a view to that item being transmitted to the relevant United Nations agencies for their consideration. Malawi sincerely hoped that WHO would not relinquish its noble role as the champion of vulnerable populations and abandon their health and development needs to others. It should remain in the forefront of the search for solutions to difficult problems like that of tobacco.

In concluding the debate, Members of the Board agreed that WHO had done all it could in relation to the economic issues connected with smoking: responsibility for further debate and action now appropriately lay with the other United Nations agencies mentioned in the report. The Director-General should therefore continue his dialogue with them, and WHO's energies should be devoted to reducing death and disease resulting from tobacco use.

The Board then adopted the following decision:

"The Executive Board, having con-

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WHO/TOH PROGRAMME

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sidered the information provided to it on the activities of WHO on matters relating to tobacco or health and the report by the Director-General to the Economic and Social Council of the United Nations in July 1991 on the social and economic issues of tobacco production, approved the action taken by the Director-General both through the orientation given to the WHO programme on "tobacco or health" and by reporting to the Council, as an appropriate and adequate response to the concerns expressed in resolutions WHA42.19 and WHA43.16 regarding the social and economic aspects of tobacco production."

Over the past few years, the Regional Committees have also emphasized the importance of tobacco control as a public health measure and have spent some time reviewing the issue. The following are some of the highlights:

The **Regional Committee for the Americas,** which is also the Directing Council of the Pan American Health Organization, discussed in September-October 1988 a document dedicated to the fight against tobacco use. In concluding its discussion on the subject, the Regional Committee requested the Regional Director to present a plan of action for the prevention and control of tobacco consumption (Resolution XXII) at the following year's meeting.

This regional plan of action proposed to the Member States of the Americas a set of strategies, activities and goals emphasizing the need for active promotion of policies, plans and programmes backed up by up-to-date information on smoking, together with indicators essential for the follow-up and evaluation of national programmes. Mobilization of resources by individual Member States was considered to be vital to the implementation of the strategies. It also underlined that the smoking situation and its consequences appeared to be worsening in most of the countries of the region, and therefore the challenge had assumed large proportions. Nevertheless, successful examples demonstrated that prevention and the control of smoking were feasible and viable.

Resolution XII (28 September 1989) approved the plan of action and urged governments to take appropriate decisions and to adopt the necessary measures required by the laws of each Member State in order to execute the plan of action effectively in their respective countries. It also requested that the Regional Director mobilize extra-budgetary resources to carry out and finance the proposed plan of action.

In September 1989, the **Western Pacific Regional Committee** selected Tobacco or Health as a topic for technical discussion at its Fortieth session.

The technical discussions reviewed the prevalence of tobacco use in the Region, discussed policies and programmes for tobacco control, and sought to identify areas in which further action could be taken by Member States. Increasing regional interest had been shown in the development of tobacco or health programmes, a great deal of information had been disseminated on the health consequences of tobacco use and many Member States had started to take action to discourage tobacco consuption. While rates of tobacco use among women in the region were relatively low, in many countries tobacco use by women was increasing while decreasing for men. The second World No-Tobacco Day, 31 May 1989, served to emphasize the need for action with its theme *"The female smoker: at added risk"*. Emphasis was put on health education, legislation and economic measures, including the need to rapidly initiate actions to find alternative employment for workers who were dependent on the tobacco industry.

The following year (September 1990), the Regional Committee adopted a regional plan of action formulated during the second Working Group on Tobacco or Health, held in Perth, Australia (March 1990). The outline of this plan has already been featured in the July 1990 issue of **Tobacco Alert.** Close monitoring of activities both by Member States and the Regional Office is an integral part of the plan.

Smoking as a risk factor was also discussed during the technical discussions on Changing Lifestyles and Health, held in conjunction with the Forty-second session of the WHO Regional Committee for the Western Pacific. Participants from the Member States placed emphasis on the further promotion of World No-Tobacco Days, the strengthening of the legislative basis, for example with regard to the protection of non-smokers, and the formulation of policies with regard to advertising and distribution practices of multinational tobacco companies to poorer countries. The session concluded by endorsing the decision of the Regional Director that health promotion should be one of the six priorities for work in the Region.

In September 1991 **the Regional Committee for Europe** reviewed the third progress report of the *"European Action Plan on Tobacco"*. It noted that countries which have been introducing tobacco control programmes were achieving success in reducing tobacco consumption and tobacco-related diseases. Nevertheless, there were more than 10 countries in the region where a continued increase in tobacco consumption was predicted. Most of these countries had yet to develop tobacco cor.trol policies and programmes, despite the growing threat to the health of their people.

The *"health for all"* evaluation also corroborated those findings. While some progress had been made in reducing smoking in the adult male population, there was a lot more to do, especially among women. This clearly showed that intensive, sustained action was essential. Impetus could easily be lost and a reversal of positive trends might occur if messages were not recast and re-emphasized, especially for young people.

The Committee adopted Resolution EUR/RC41/R8 which dealt with the evolution towards a *"Smoke-free*

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WHO/TOH PROGRAMME

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Europe". This energetic resolution calls on Member States to launch or enhance and evaluate the implementation of comprehensive and effectively funded and managed campaigns to increase the number of non-smokers, particularly among women and adolescents, to at least 80% of the total population by the year 2000. It also invites Member States to promote the principle that all health and educational premises are free from tobacco smoke (with the exception of strictly limited designated smoking areas in hospitals) and tobacco sales, to introduce programmes that foster the exemplary role of health professionals and teachers as non-smokers and to ensure the availability of support for smokers who wish to stop smoking. It invites Member States to join in celebrating World No-Tobacco Day on 31 May each year and to focus on the themes approved by the Director-General.

The European Region was the first of the WHO regions to adopt a specific action plan on tobacco in 1987. The original plan included activities up to 1991/1992. The Committee renewed its commitment to an effective tobacco control policy by asking the Regional Director to draw up a new action plan, which will be adopted at the next committee meeting.

CESSATION

SMOKING PREVENTION IN SIBERIA

Novosibirsk is a major scientific and industrial centre of Siberia. Although it is a young city, celebrating its hundredth anniversary in 1993, it has a population of more than one-and-a-half million.

Scientists from the Institute of Internal Medicine of the Siberian branch of the Russian Ac l-emy of Medical Sciences study the prevalence of ischaemic heart disease (IHD) risk factors, including smoking, among Novosibirsk residents in the framework of the WHO programme CINDI (countrywide integrated noncommunicable diseases intervention programme). According to the screening carried out in 1988-1989, the prevalence of smoking was 56.4% among men and 4.4% among women. The average number of cigarettes smoked during 24 hours was 16.2 among men and 6.6 among women; 8% of boys aged 10-14 and 40% of boys aged 17 were smokers.

Owing to the cultural traditions of Siberia, a number of women concealed the fact that they smoked. However, smoking was proved by the existence of an increased level of thiocyanate (6.6 mcmol/1) in the blood serum of 19% of women. In men this parameter corresponded to the data of the interview - 56%.

In order to lower the prevalence of smoking among the population, scientists from the Institute of Internal Medicine have applied a system of smoking prevention among the general public which consists of the following stages:

1. Information stage: through mass media and during preventive examinations the general public is informed about the dangers of smoking and about the existence of the Smoking Prevention Centre.
2. Diagnostic stage: at the Centre, individuals who wish to give up smoking undergo special psychological examinations to establish their smoking habits; account is also taken of their personal characteristics so that an individual approach to treatment can be taken.
3. Treatment stage: depending on the results of psychological examination, the individual is treated by one or several specialists (psychotherapist, reflexotherapist, narcologist).
4. Psychological support stage: two years after the first visit to the Centre, participants are invited to a follow-up session where a physician encourages people who have successfully quit smoking to remain non-smokers.

Follow-up data collected by the Centre indicate a very significant decline in smoking prevalence among participants in the programme. New methods to ensure that treatment is more effective are still being developed.

EPIDEMIOLOGY

MEDICAL STUDENTS AND SMOKING: A WORLDWIDE SURVEY

In 1985, on the initiative of Sir John Crofton, Chairman of the Smoking and Health Committee, the International Union against Tuberculosis and Lung Disease (IUATLD) decided to launch a pilot survey on *"Medical students and smoking"*. This pilot study covering Algeria, Czechoslovakia, Egypt, France and Turkey, carried out at the start of the first year and the end of the final year of medical studies, showed, among other things, the present shortcomings in teaching about the risks of smoking and the little importance attached by students to prevention and to their own role in tobacco control. Contrary to what might have been hoped, the shortcomings in the first year were far from being corrected by the end of the course.

On the basis of the pilot study, IUATLD decided to finance a worldwide survey at 50 centres in 45 countries. For this, it obtained the support and sponsorship of WHO. The work was carried out by the Smoking and Health Committee (Chairman Professor P. Fréour) and by the Biostatistics Department of the University of Bordeaux with Dr J.F. Tessier. The level of participation was excellent and the results summarized below are on the whole reliable (questionnaire validated and translation checked).

- Tobacco consumption varies widely from country to country and by sex. On the whole, consumption is much higher in the final year of medical studies than in the first year.
- Knowledge varies widely from country to country. The differences between the first and final years are by no means the same everywhere: very small in some countries, moderate in many others, considerable in a few. Teaching varies greatly and the results are very uneven. It is interesting to note that a great deal of knowledge is already acquired in the first year.
- It is noteworthy that students on the whole regard their own smoking as a temporary phenomenon: many believe they will no longer be smoking in five years' time. Quite a number have already stopped smoking and many smokers would like assistance in giving up. These, of course, are *"stated"* studies.
- Among the students as a whole, even in the fifth year, there are few who feel concerned by their role in preventing smoking and assisting smokers to quit. This is a very striking shortcoming, confirming that, except in a very few countries, physicians concentrate on diagnosis and treatment and not on prevention. This situation is also reflected in the replies to the question on anti-smoking legislation.
- Overall, there are no differences in replies by sex.
- Overall, there are few differences in attitudes and behaviour between the first and final years, so there is a need to do something about the curriculum.
- The factor that determines the differences is whether the student is a smoker or non-smoker (ex-smokers reply like non-smokers). The fact of smoking is therefore no trivial matter. It changes the attitude towards smoking, modifies *"the weight of this risk factor in my life as a physician and in my medical behaviour, modifies the priority I give to prevention and to certain legislative aspects"*.

This survey has led to the proposal of two initiatives:

- One (Sir John Crofton) concerns a WHO-assisted study, starting in Europe, which would address deans and directors of medical schools in an attempt to determine the place assigned in the curriculum to smoking and its control, and to consider ways of improving the teaching situation.
- The other (P. Fréour and J.F. Tessier) concerns the organization of a follow-up to the survey, starting in Europe, with WHO assistance. This follow-up would be performed every five years by a simplified procedure, so as to provide a small number of simple but significant indices for monitoring the trend over time in the major parameters of the survey.

This seems very useful, because the physicians of tomorrow – the students of today – will long play a decisive role in smoking control. This becomes clear when we compare smoking by students and smoking by physicians and by the general public in some countries of the survey. We need to ensure that physicians – and other members of the health profession – become the leaders in the fight against smoking in all countries.

The following publications give more detailed information on the survey:

— Pilot survey: **Revue de Santé Publique,** 1988, No. 2, 21-30;

— Results for Europe: **Eur. J. Epidemiol.** 1989, Vol. 5, No. 3, 311-321;

— Results for Asia: in the **International Journal of Epidemiology;**

— Results for Africa: in preparation;

— Results for Australia, Japan, United States and USSR: in preparation.

SOCIETY

A NEW GENERATION OF WARNINGS

Warning!
This area contains tobacco smoke, which is known to cause cancer, heart disease, lung disease, and may harm your baby.
By-law 406-79
Medical Officer of Health
City of Toronto

NEWS BRIEF

IT IS NEVER TOO LATE TO GIVE UP SMOKING

Older people who think it is no longer worthwhile for them to give up smoking are wrong, according to the findings of a study of 7 178 men and women aged 65 and over in Massachusetts, Iowa and Connecticut. It emerges clearly that even long-standing smokers have a chance of living longer if they give up the harmful habit.

After only a few years, the risk of cardiovascular mortality for ex-smokers reverts to a level identical with that of those who have never smoked. However, ex-smokers still run a higher risk of cancer, but women, in particular, stand to benefit from giving up smoking after the age of 65.

SOCIETY

PROHIBITION OF SMOKING AT THE WORKPLACE AND SMOKING CESSATION IN GERMANY

In some countries, findings regarding the negative health consequences of passive smoking have led to stricter smoking regulations in public buildings, transportation systems and workplaces. While these measures are clearly suited to reducing exposure to passive smoking, they may also help active smokers to quit or reduce smoking. Plausible mechanisms for such an effect may be: increased inconvenience of smoking; reduced temptation due to the fact that workplace colleagues are also prohibited from smoking; and a potential training effect of enforced tobacco-free time intervals. These mechanisms could both encourage smokers to make an effort to quit as well as making cessation attempts more successful.

In a series of studies recently reported from Australia, Canada and the United States, the short term effects (3-20 months) on smoking behaviour of newly introduced smoking bans at the workplace have been evaluated by single post-implementation surveys, or, in most cases, by two or three cross-sectional surveys before and shortly after the introduction of the smoking ban. A prospective cohort approach was used in only a few studies which reported substantial losses of participants in the follow-up phases. Overall, most studies found some reduction in the numbers of cigarettes smoked per day by active smokers, but some of the studies found that the smoking ban had little or no effect on smoking cessation.

In a recent study conducted in the former Federal Republic of Germany in 1987, the relationship between prohibition of smoking at the workplace and smoking cessation was assessed on a national sample. Four hundred and thirty-nine men and women aged 21 to 65 years, who were actively engaged in the workforce for at least 20 hours per week and were either current or former smokers, were included in the study.

Quit ratios were substantially higher for women who worked at tobacco-free workplaces compared to women who were allowed to smoke at their workplace. Among men, there were only minor differences between both types of workplace. After simultaneous control for age, marital status and level of school education by multiple logistic regression, the odds ratio of being a current smoker (vs. former smoker) was 0.80 (95% confidence interval 0.44-1.45) for men and 0.22 (95% confidence interval 0.09-0.50) for women working at places where smoking was prohibited (compared with men and women who were allowed to smoke at the workplace).

Since these data are from a single cross-sectional survey, they do not reveal the temporal sequence, or the possible causal relationship, between workplace smoking policies and quitting smoking; they only reveal an association between the variables, particularly for women.

Nevertheless, the results do suggest that prohibition of smoking in the workplace is associated with a higher frequency of smoking cessation, particularly among women.

Prohibition of smoking at the workplace might therefore be a particularly cost-effective public health measure. It costs little to implement, provides effective protection from involuntary exposure to tobacco smoke and may encourage some smokers, especially women, to quit smoking.

These results are of particular interest with regard to the celebration of World No-Tobacco Day 1992, of which the theme is "Tobacco-free workplaces"

ADJUSTED ODDS RATIOS (OR) WITH 95% CONFIDENCE INTERVALS (95% CI) FOR CURRENT VS. FORMER SMOKING AMONG EVER SMOKERS OF CIGARETTE

Sex	by variable		OR (95% CI)
Men	Smoking at workplace	allowed	1.00*
		not allowed	0.80 (0.44-1.45)
	Age	21-35 years	1.00*
		36-50 years	0.71 (0.36-1.37)
		51-65 years	0.37 (0.18-0.78)
	Marital status	never married	1.00*
		married	0.89 (0.44-1.78)
		widowed/divorced	0.52 (0.14-1.97)
	School education	≤ 9 years	1.00*
		10-11 years	0.89 (0.44-1.78)
		≥ 12 years	0.41 (0.22-0.75)
Women	Smoking at workplace	allowed	1.00*
		not allowed	0.22 (0.09-0.50)
	Age	21-35 years	1.00*
		36-50 years	0.74 (0.28-1.95)
		51-65 years	0.29 (0.06-1.35)
	Marital status	never married	1.00*
		married	0.69 (0.26-1.86)
		widowed/divorced	0.55 (0.14-2.18)
	School education	≤ 9 years	1.00*
		10-11 years	0.26 (0.10-0.71)
		≥ 12 years	0.20 (0.06-0.62)

* Reference group

LEGISLATION

TOBACCO ADVERTISING IN THE CZECH AND SLOVAK FEDERAL REPUBLIC

Reports from Prague repeatedly mention that advertising of tobacco products is now a prominent feature in the Czech and Slovak Federal Republic (CSFR), with advertisements appearing in shop windows, and on billboards, buses and trams. This situation is particularly curious, since three new laws have recently been adopted, all ostensibly intended to provide some controls on the advertising of tobacco and other dependence-producing products. However, a closer inspection of these laws reveals certain legal shortcomings, the combined effect of which is to allow tobacco advertising to continue, with no restrictions.

In 1989, the Czech National Council adopted Law No. 37, while the Slovak National Council adopted Law No. 46. Both statutes were designed to provide protection against alcoholism and other forms of drug dependence, including smoking. Thus, the Czech law includes a prohibition on the sale of cigarettes to persons under 16 years of age; it restricts smoking to specially designated smoking areas in public transport vehicles and certain public places (such as sports arenas and cafeterias). It also prohibits the advertising of "smoking" in the press and other mass communications media. In practice, however, the authorities of the Czech Republic are interpreting "smoking" very narrowly, so that the Law only prohibits advertisements that show pictures of people with lit cigarettes in their mouths. As the public in countries where tobacco advertising is permitted knows only too well, a broad range of powerful tobacco advertising imagery is possible without ever showing a person actually smoking.

The legal situation was further complicated in 1991, when the Federal Assembly of the CSFR passed a third Law dealing with broadcast advertising; one Section of that Law lays down that broadcasters may not transmit "commercials encouraging behaviour constituting a threat to morality, the consumer's interest or the interests of health protection, public security or the environment". Unfortunately, another Section in the same Law states that broadcast tobacco advertisements are required to include information on tar and nicotine levels, together with a warning that smoking is detrimental to health. This Law is thus being interpreted to mean that broadcast tobacco advertisements that comply with these requirements are permissible, and do not fall in the class of commercials "constituting a threat to ... health promotion".

There have thus been problems in the interpretation of Law No. 37 of the Czech National Assembly, conflicts within the Federal Law, and conflicts between the Federal Law and those of the two Republics. The net result of these difficulties is that tobacco advertising has escaped effective legal control in the CSFR, despite the existence of legislation aimed at controlling tobacco advertising.

In a 1990 resolution, the World Health Assembly invited Member States to consider passing legislation to control tobacco advertising. However, it is not sufficient that such legislation be passed. To be effective, it must also be drafted clearly, and not subject to multiple interpretations. There is also a need to ensure that the legislation is internally consistent, and that it does not conflict with other laws of the country. Moreover, the law, once passed, needs to be enforced. This implies that a system of surveillance and enforcement to administer the law should be in place as soon as the law comes into force.

The CSFR has begun to implement a comprehensive tobacco control policy, which represents an essential first step. As the country gains experience in the implementation of this policy, there will no doubt be opportunities in the future to improve the current legislation dealing with the advertising of tobacco products.

WHO/TOH PROGRAMME

WHO'S IN CHARGE IN WHO?

The vital statistical and epidemiological component of WHO's Tobacco or Health programme has been significantly strengthened by the transfer of Dr Alan Lopez, who joined the programme in February 1992. Dr Lopez holds degrees in mathematics, statistics, and medical demography and has worked for over a decade with WHO's Health Situation and Trend Assessment Programme (HST), mainly on the analysis of causes of death and the assessment of smoking-attributable mortality. Dr Lopez will be primarily responsible for the development of WHO's new Tobacco or Health data centre.

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